LEGISLATIVE AUDIT DIVISION

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November 2008

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the medical and pharmacy claims for the employee benefits plans at the State of Montana for the two plan years ended December 31, 2007, and the Montana University System for the two plan years ended June 30, 2008.

The audit was conducted by Wolcott & Associates under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agencies' written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

Tori Hunthausen, CPA
Legislative Auditor

08C-09

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STATE OF MONTANA and
MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF
CLAIMS PROCESSING
FOR THE PERIOD
JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

TRADITIONAL PLANS

ADMINISTERED BY

BLUE CROSS BLUE SHIELD OF MONTANA,
ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. and
DELTA DENTAL PLAN

FINAL REPORT

NOVEMBER, 2008

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
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STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
TRADITIONAL HEALTH CARE PLAN AUDIT
OF BLUE CROSS BLUE SHIELD OF MONTANA,
ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. and
DELTA DENTAL PLAN
JANUARY 1, 2006 - DECEMBER 31, 2007

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EXHIBITS

I - INTRODUCTION

The State of Montana (State) provides self-funded medical care and dental care benefits as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered lives.

The State has negotiated a contract with Blue Cross Blue Shield of Montana (BCBSMT) to provide administration services to its indemnity medical and dental plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and had also contracted to have their medical and dental care benefits administered by BCBSMT until June 30, 2005. However, as of July 1, 2005 MUS contracted with Allegiance Benefit Plan Management, Inc. (Allegiance) to administer their medical and dental care benefits. MUS contracted with Delta Dental as of July 1, 2007 to administer their dental care benefits. The plan covers approximately 8,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years and subsequently renewed that contract for the 2004-2005 Plan Years and the 2006-2007 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the contract would be renewed May 15, 2008. All preliminary work was completed and on-site services were performed in August, 2008.

On-site audit services were performed at:

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Allegiance Benefit Plan Management, Inc.
2806 South Garfield Street
Missoula, Montana 59801

Delta Dental Plan
1000 Mansell Exchange West, Bldg. 100, Suite 100
Alpharetta, Georgia 30022

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care and dental care benefit claims paid by BCBSMT during the period from January 1, 2006 through December 31, 2007 for State. Test work was performed on 211 claims for State, all of which were selected on a stratified, random (statistical) basis.

The scope of audit services covered medical care and dental care benefit claims paid by Allegiance during the period from January 1, 2006 through December 31, 2007 for MUS. Test work was performed on 211 claims for MUS, all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.

- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.
- Consistency of payments to BCBSMT and Allegiance member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

II - STATISTICAL CLAIM AUDIT RESULTS - BCBSMT

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 211 claims processed at BCBSMT.

The State claims were selected from the population of claims paid by BCBSMT between January 1, 2006 and December 31, 2007. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 211 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 211 claims, processed by BCBSMT, in our statistical sample, 7 were judged to contain a payment error. This represents a frequency of payment error of 3.3%.

Our sample contained a total payment of $906,121.40 for the 211 claims. The overpayments totaled $8,528.00 or 0.94% of the total. The underpayment totaled $147.45 or 0.02% of the total. This financial error rate is within the range of .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 1%. However, it is less favorable than the 0.02% reported in the prior audit report.

The frequency of payment error in our sample is within the range of three to five percent error rate normally observed during our audits of similar plans. However, it is less favorable than the BCBSMT standard of 3%. In addition, the error rate is less favorable than the 1.9% error rate reported in the prior audit report.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 1.9%, that the true frequency of error in the population is within the range of 1.4% to 5.2%.

Based on this extension, we believe that the true magnitude of payment error in the population

is $1,075,498 or (1.1% of payments in the population). The magnitude of payment error is the sum of $996,396 in projected overpayments plus $79,102 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

A summary of error by type for BCBSMT is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of coinsurance	2	90.73 net
Blue Card Issue	1	103.76
Incorrect override by processor	1	6,600.00
Incorrect adjustment performed	2	1,762.02
Incorrect application of allergy shots	1	5.50
Total	7	$8,380.55

BCBSMT has included their response as **Exhibit C**.

RECOMMENDATIONS

Our recommendations are as follows:

- We identified 2 claims that the coinsurance and/or deductible was not correctly applied. BCBSMT has indicated that this is a system issue and is currently being reviewed. We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

- We identified 2 claims that had adjustments made to them after the original processing of the claim. The adjustments were warranted and were for late charges and correction of pricing. Upon the performance of the adjustments, the processor failed to apply the coinsurance provisions to the claims.

  We recommend that BCBSMT perform enhanced training in this area and conduct an analysis of all adjustments, in order to determine if other overpayments exist.

- We identified an issue unique to the Blue Card program. If the allowance of a charge submitted through the Blue Card program is greater than the billed amount, BCBSMT will pay 100% of the charge, instead of applying deductible and/or coinsurance.

  We recommend BCBSMT discontinue this practice and conduct an analysis, in order to identify overpayments caused by this procedure.

III - STATISTICAL CLAIM AUDIT RESULTS - ALLEGIANCE

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 211 claims for MUS.

The MUS claims were selected from the population of claims paid by Allegiance between January 1, 2006 and December 31, 2007. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 211 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on Allegiance's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that Allegiance is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 211 MUS claims in our statistical sample, 2 was judged to contain a payment error. This represents a frequency of payment error of .95%.

Our sample contained a total payment of $680,678.30 for the 211 claims. There were no overpayments identified. The underpayments totaled $75.00 or 0.01% of the total.

This financial error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the Allegiance standard of 1%.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the Allegiance standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 0.5%, that the true frequency of error in the population is between .45% and 1.45%.

Based on this extension, we believe that the true magnitude of payment error in the population is $1,590 or (0.003% of payments in the population). The magnitude of payment error is the sum of $1,590 in projected overpayments plus $0 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type for Allegiance is presented below:

ALLEGIANCE HEALTH CARE CLAIMS
JULY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of ER copay	2	(75.00)
Total	2	$(75.00)

Allegiance has included their response as **Exhibit D**.

RECOMMENDATION

Our recommendations are as follows:

- We identified 2 errors involving the misapplication of the emergency room copay. This issue was identified in the last audit that was performed at Allegiance for MUS.

  We believe Allegiance should perform enhanced training for the processors responsible for the administration of the MUS traditional plan.

  In response to our recommendation, Allegiance has indicated that they have upgraded the system code, in order to adjudicate these types of claims correctly.

IV - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT and Allegiance. This section describes the methods employed and presents the results of the verification of eligibility for the 422 (211 for the 2 plan sponsors) in our sample where a payment was made by BCBSMT or Allegiance.

STATE OF MONTANA

The State prepares and sends to BCBSMT a biweekly eligibility tape showing each individual to be covered for the coming month. BCBSMT runs this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM - ALLEGIANCE

Allegiance receives the enrollment data from each campus on a daily basis. The enrollment information is then updated in Allegiance's system.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the Allegiance's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

V - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 422 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the date the claim was processed.

Results, by plan sponsor, are presented below.

STATE of Montana - BCBSMT

For all 211 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	3
Median	24
Mode	1

BCBSMT informed us that company policy for turnaround time is 97% of claims is to be paid within 30 days.

MUS - ALLEGIANCE

For all 211 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	8
Median	6
Mode	4

Allegiance informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

VI - COST CONTAINMENT

Discussion regarding cost containment procedures utilized at BCBSMT and Allegiance is presented below.

CASE MANAGEMENT

BCBSMT

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. The notification procedure is used to alert APS Healthcare Northwest, Inc. (the case management firm utilized by the plans) of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, APS has indicated that they receive these referrals from BCBSMT and in some cases from the hospital.

This procedure is can be initiated by either the individual or the provider of services.

BCBSMT indicated that there were 34 denials in 2006 and 26 denials in 2007 for the State Plan.

It should be noted that the plan document indicates that all DME in excess of $1,000 should be pre-authorized. However, BCBSMT does not require this process for any of its book of business. Therefore, they have indicated that the State and MUS have agreed to the BCBSMT's policies and procedures regarding DMEs in excess of $1,000.

Allegiance

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. Allegiance utilizes the services of StarPoint for the preauthorization process. The notification procedure is used to alert StarPoint of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, StarPoint has indicated that they receive these referrals from Allegiance and in some cases from the hospital.

This procedure can be initiated by either the individual or the provider of services.

Allegiance indicated that there were 3 denials for the 2006-2007 for the MUS Plan.

FACILITY DISCOUNTS

BCBSMT

Each sample facility claim was reviewed for the appropriate facility discount. In addition, we reviewed the congruency (multiple claims for same facility) of application of the facility discount.

We did not identify any errors as it pertains to the application of facility discounts.

We did identify 6 claims where the billed amount equaled the allowed amount (2%). Four of the six were from 2 different facilities in which BCBSMT does have a discount arrangement with which they participate in the program. However, for the audit period, these two facilities did not participate in the program.

Allegiance

Each sample facility claim was reviewed for the appropriate facility discount. In addition, we reviewed the congruency (multiple claims for same facility) of application of the facility discount.

We did not identify any errors as it pertains to the application of facility discounts.

We did not identify any facility claims where the billed amount equaled the allowed amount.

DISCOUNTS

Blue Card Program - BCBSMT

BCBSMT participates in a program called "Blue Card". This program allows members to receive treatment outside of Montana and still receive discounts through the Blue Cross Blue Shield organization. The claims are submitted to the "host plan" (the Blue Cross Blue Shield organization in the State in which services were rendered). The claim processes through the ITS system and is relayed to the BCBSMT system for payment.

During our audit of claims, we reviewed several claims in which services were rendered outside the State of Montana and claims were processed through the Blue Card (ITS) system.

We did identify one issue with a claim processed through this system. The issue involved the allowable amount for a service was greater than the billed amount. Therefore, the system processed that charge at 100% without applying deductible and coinsurance. We have recommended BCBSMT address this issue and identify any other overpayments caused by this system issue.

Cascading Network Arrangements - Allegiance

The MUS plan participates in a cascading network arrangement offered through Allegiance. This arrangement allows for services that may not be discounted through the Allegiance PPO network to be discounted through another network (MultiPlan, Beechstreet, etc.).

During our audit of claims, we identified several claims in which the cascading network arrangement applied. We did not identify any issue with these claims. Therefore, we conclude that the cascading network arrangement is being applied appropriately.

ACCESS FEES

BCBSMT

During our review of Blue Card claims, we reviewed the application of the access fees that were charged to the State Plan for the use of the Blue Card system.

The fees that were charged to the Plan were in accordance to the contract between BCBSMT and the State of Montana.

Allegiance

During our review of the claims processed, we noted that the only access fees that were applied and charged to the MUS plan were those from MultiPlan. MultiPlan is service that charges based on a percentage of savings. MultiPlan is utilized for non-network claims.

We believe that is in agreement with the contract between Allegiance and MUS.

AGENT COMMISSIONS

We discussed the issue of agent commissions with both BCBSMT and Allegiance. Both vendors indicated that no agent commissions were being charged to either Plan.

We believe that is in agreement with the contract between the State, MUS and both vendors.

HIGH DOLLAR CLAIM REVIEW

BCBSMT

We reviewed the high dollar claim review process with BCBSMT. They indicated that all claims above $50,000 are subjected to audit by a senior manager. In addition, all line items in excess of $5,000 are subjected to audit by a senior manager.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

Allegiance

We reviewed the high dollar claim review process with Allegiance. They indicated that all claims processed with payment amounts between $10,000 and $25,000 are subjected to audit by an intermediate claims examiner. Claims that are processed with payment amounts between $25,000 and $100,000 are subjected to audit by the claims manager. Claims that are processed with payment exceeding $100,000 are subjected to audit by the director of claims.

The two errors that we did identify during our audit would have been subjected to the high dollar review. However, the errors were not identified. Therefore, we recommend that Allegiance perform enhanced training for the individuals reviewing the high dollar claims.

VII - OTHER REVIEW AREAS

The results of our review in areas requested by the two plan sponsors is as follows.

HIPAA POLICIES

BCBSMT

We reviewed the BCBSMT HIPAA policy (10 parts).

We believe the policy is extensive and thorough. Further, we believe that BCBSMT has taken the appropriate measures to ensure that the policies are applied and followed by the personnel at BCBSMT.

Allegiance

We reviewed the Allegiance HIPAA policy.

We believe the policy is extensive and thorough. Further, we believe that Allegiance has taken the appropriate measures to ensure that the policies are applied and followed by the personnel at Allegiance.

PERFORMANCE GUARANTEE RESULTS

BCBSMT

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM QUALITY					
Financial Payment	Accuracy of paid benefit $	99.0%	Calculated as the total audited "paid" dollars minus the absolute value of over and under payments, divided by total audited paid dollars.	99.04%	98.25% in 2006 99.19% in 2007
Payment Incidence Accuracy	Incidence of claims processed without payment error	97.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims	96.7%	95% in 2006 97.7% in 2007
CLAIM TIMELINESS					
Turnaround Time in 30 Calendar Days	Timeliness of claims processing	95%	Plan will pay 95% of clean claims within 30 calendar days and 95% of all claims (paid or denied within 60 Calendar Days.	99.53% 100%	91.75% in 2006 & 97.9% in 2007 (within 14 days)

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CUSTOMER SERVICE					
Telephone Response Time	Timeliness of customer service call answer	90% answered in 30 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a CSR.	N/A	Not supplied
Call Abandonment Rate	The percentage of calls that are abandoned before answer	3% or less	Percentage of calls that reach the vendor and are placed in member service queue, but are not answered because caller hangs up before CSR is available.	N/A	8.09% in 2006 2.26% in 2007
First Call Resolution	Percentage of calls that are handled to conclusion on first call	85%	A call that is resolved during or after the call is received, and does not result in a follow-up call from the member regarding the same issue within 30 calendar days.	N/A	Not supplied by vendor
Call Quality	Average percentage of customer service quality points earned per monitored call	85%	Call quality is measured by monitoring a random sample of calls answered by the Member Services Call Center. The sample is reviewed to determine the percentage of customer service quality points earned.	N/A	78.84% in 2006 84.22% in 2007

Category	Measure	Target	Definition	Audit Finding	Vendor Result
ADMIN.					
ID Cards	Percentage of ID cards sent with correct info. within 5 business days of receipt of eligibility file	99%	Requires the plan to send at least 99% of ID cards with correct information within 5 business days of receipt of clean eligibility data.	N/A	71.8% (results for audit period)

Allegiance (as of 7/1/07)

Allegiance indicated to us that this was not a requirement for MUS until 7/1/07. Therefore, the results are only for 7/1/07 through 3/31/08.

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM QUALITY					
Financial Payment	Accuracy of paid benefit $	99.0%	Calculated as the total audited "paid" dollars minus the absolute value of over and under payments, divided by total audited paid dollars.	99.99%	99.9%

Category	Measure	Target	Definition	Audit Finding	Vendor Result
Payment Incidence Accuracy	Incidence of claims processed without payment error	97.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims	99.05%	99.48%
CLAIM TIMELINESS					
Turnaround Time in 30 Calendar Days	Timeliness of claims processing	95%	Plan will pay 95% of clean claims within 30 calendar days and 95% of all claims (paid or denied within 60 Calendar Days.	100% 100%	99.32%
CUSTOMER SERVICE					
Telephone Response Time	Timeliness of customer service call answer	90% answered in 30 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a CSR.	N/A	98.31%
Call Abandonment Rate	The percentage of calls that are abandoned before answer	3% or less	Percentage of calls that reach the vendor and are placed in member service queue, but are not answered because caller hangs up before CSR is available.	N/A	1.98%

Category	Measure	Target	Definition	Audit Finding	Vendor Result
First Call Resolution	Percentage of calls that are handled to conclusion on first call	85%	A call that is resolved during or after the call is received, and does not result in a follow-up call from the member regarding the same issue within 30 calendar days.	N/A	93.02%
Call Quality	Average percentage of customer service quality points earned per monitored call	85%	Call quality is measured by monitoring a random sample of calls answered by the Member Services Call Center. The sample is reviewed to determine the percentage of customer service quality points earned.	N/A	96.14%
ADMIN.					
ID Cards	Percentage of ID cards sent with correct info. within 5 business days of receipt of eligibility file	99%	Requires the plan to send at least 99% of ID cards with correct information within 5 business days of receipt of clean eligibility data.	N/A	99.98%

VIII - DELTA DENTAL REVIEW

The results of our audit of claims processed at Delta Dental Plan are presented in this section.

SAMPLE SIZE AND METHODOLOGY

MUS contracted with Delta Dental Plan (DDP) beginning July 1, 2007 for the administration of dental claims. We chose a random sample of 35 claims for the period July 1, 2007 through December 31, 2007. Due to the short length of time for the audit period, we believe this sample was sufficient. In future audit periods, a larger sample will be selected for audit.

AUDIT PROCEDURE

Information presented below describes our test work on the 35 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on DDP's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

- Review provider contracts and claim system, in order to verify that balance billing is not allowed for network provider services.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 35 MUS dental claims in our, none were judged to contain a payment error. This represents an accuracy rate of 100%

DDP PERFORMANCE GUARANTEE

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM QUALITY					
Financial Payment	Accuracy of paid benefit $	>99.0%	Calculated as the total audited "paid" dollars minus the absolute value of over and under payments, divided by total audited paid dollars.	100%	99.6%

Category	Measure	Target	Definition	Audit Finding	Vendor Result
Payment Incidence Accuracy	Incidence of claims processed without payment error	>98.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims	100%	99.4%
Claims Processing Accuracy	Incidence of claims processed without any error	>97%	Calculated as the total number of audited claims minus the number of claims processed with error, divided by the total number of audited claims	100%	99.6%
CLAIM TIMELINESS					
Turnaround Time in 14 Calendar Days	Timeliness of claims processing	90%	TAT is measured from the date a claim is received by DDP to the date it is processed for payment, denial, or pended for other information.	94%	96.8%

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CUSTOMER SERVICE					
Telephone Response Time	Timeliness of customer service call answer	90% answered in 30 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a CSR.	N/A	91.53%
Call Abandonment Rate	The percentage of calls that are abandoned before answer	3% or less	Percentage of calls that reach the vendor and are placed in member service queue, but are not answered because caller hangs up before CSR is available.	N/A	0.40%
First Call Resolution	Percentage of calls that are handled to conclusion on first call	90%	A call that is resolved during or after the call is received, and does not result in a follow-up call from the member regarding the same issue within 30 calendar days.	N/A	99%

Category	Measure	Target	Definition	Audit Finding	Vendor Result
Grievance Reporting	Tracking, monitoring of grievance activity; resolution; provision of summary reports	Non-complex be resolved within 2 working days. Complex grievance involving clinical care issues will be resolved within 30 working days.	Grievances will be tracked by type of grievance and MUS will receive quarterly reports summarizing grievance activity by type of grievance. Information regarding type of grievance will also be included.	N/A	Not supplied by vendor
Reporting	On-time delivery of quarterly and annual reports	100%	Quarterly reports will be delivered by no later than 30 days following the close of the quarter; annual reports will be delivered by no later than 45 days following the close of the plan year.	100% 100%	100% 100%

IX - PRIOR AUDIT RECOMMENDATIONS

The most recently completed audit for the State of Montana and Montana University System, was performed for the period January 1, 2004 through December 31, 2005.

The report for that audit, issued in December, 2006, contained the following recommendations:

BCBSMT

Data Entry

We identified 2 errors that were due to clerical (data entry) errors. We recommend that further training be conducted, in order to avoid these types of errors in the future.

BCBSMT response: These issues were communicated to the individuals, and their Management reviewed the training issues with them.

QNXT issue

We identified 2 claims that the coinsurance was not correctly applied. One of these errors was processed on the new claim system, Qnxt. BCBSMT has indicated that this is a system issue and is currently being reviewed. We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

BCBSMT response: The QNXT system fix applicable to the issue noted above was completed in September, 2006, and an auto adjustment was performed on affected claims.

EXHIBIT A

STATE OF MONTANA
TRADITIONAL HEALTH CARE CLAIM AUDIT - BCBSMT
CLAIMS PROCESSED FROM JANUARY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF FINDINGS

CLAIM #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
07060S00291A1	1,351.62	1,247.86	103.76	QNXT system issue. Blue Card claim where one charge has an allowable greater than the charge amount. System is paying these types of charges at 100% rather than applying coinsurance and deductible.
05363e01831	1,330.04	1,477.49	(147.45)	Claim processed on the same day as another claim for same patient. The claims do not "see" each other and therefore, the deductilbe and accumulators are applied to both claims incorrectly.
06128e03237	226.85	170.13	56.72	QNXT system issue with accumulators. Claim should have had coinsurance applied, in order to satisfy the patient's out-of-pocket.
05343e04492a1	2,000.00	1,500.00	500.00	When this claim was adjusted to correct the pricing on the claim, the adjustor did not reprocess the claim applying the coinsurance provision.
06089e00152	11,607.67	5,007.67	6,600.00	The preauthorization for this inpatient stay at an acute care facility was denied. However, when the claim suspended for review the processor over-rode the denial, which caused the overpayment.
06138e01214a1	19,388.17	18,126.15	1,262.02	Claim was adjusted due to late charges submitted by the hospital. However, when the adjustment was performed, the coinsurance was not applied. The issue was identified by BCBSMT, but this claim was missed in the mass adjustment process.
06107e03071a1	22.00	16.50	5.50	Claim for allergy shot was incorrect processed. System was set-up incorrectly. Claim was adjusted prior to our audit.
	35,926.35	27,545.80	8,380.55	

EXHIBIT B

MONTANA UNIVERSITY SYSTEM
TRADITIONAL PLAN CLAIM AUDIT - ALLEGIANCE
SUMMARY OF FINDINGS
AUDIT PERIOD JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
19,486.39	19,511.39	(25.00)	Should not have applied ER copay for inpatient claim.
24,460.97	24,510.97	(50.00)	Should not have applied ER copay for inpatient claim.
43,947.36	44,022.36	(75.00)	

BlueCross BlueShield of Montana
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560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

November 24, 2008

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Traditional Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana Traditional claim audit recently completed for the audit period January 1, 2006 through December 31, 2007.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) responses to the Summary of Findings in Exhibit A, Recommendations, and Prior Audit Recommendations.

Exhibit A

Claim	
State	QNXT system issue. Blue Card claim where one charge has an allowable greater than the charge amount. System is paying these types of charges at 100% rather than applying coinsurance and deductible. (Overpaid $103.76) **Comment:** BCBSMT agrees with this finding, however, disagrees with the amount of payment error assessed. In general, when the allowed amount for a claim is greater than the charge, coinsurance is calculated from the charge. In this case, the allowed amount was $518.82, the charge $316.20 and the calculated coinsurance (20%) would have been $63.24. Therefore the Overpayment is $63.24. No adjustment will be made to the audit claim because claims that processed after this claim allowed the member to meet the out of pocket limit. We have investigated and will discuss materiality and resolution of this issue with the group.

State	Claim processed on the same day as another claim for same patient. The claims do not "see" each other and therefore, the deductible and accumulators are applied to both claims incorrectly. (Underpaid $147.45) **Comment:** BCBSMT agrees with this finding, however, the deductible and accumulator were applied incorrectly on one claim only. The audit claim processed in January 2006. The system coding was corrected September 2006. We will investigate and discuss materiality and resolution of this issue with the group.
State	QNXT system issue with accumulators. Claim should have had coinsurance applied, in order to satisfy the patient's out-of-pocket. (Overpaid $56.72) **Comment:** BCBSMT agrees with this finding. The Audit claim was processed in May, 2006. The system coding was corrected in September 2006. We will investigate and discuss materiality and resolution of this issue with the group.
MUS	When this claim was adjusted to correct the pricing on the claim, the adjustor did not reprocess the claim applying the coinsurance provision. (Overpaid $500.00) **Comment:** BCBSMT agrees with this finding. We will investigate and discuss materiality and resolution of this issue with the group.
State	The preauthorization for this inpatient stay at an acute care facility was denied. However, when the claim suspended for review the processor over-rode the denial, which caused the overpayment. (Overpaid $6,600.00) **Comment:** BCBSMT agrees with this finding. This was determined to be a clerical error and has been addressed through notification and additional training for the processor. We will discuss resolution of this issue with the group.
State	Claim was adjusted due to late charges submitted by the hospital. However, when the adjustment was performed, the coinsurance was not applied. The issue was identified by BCBSMT, but this

claim was missed in the mass adjustment process. (Overpaid $1,262.02)

Comment: BCBSMT agrees with this finding. We will discuss materiality and resolution of this issue with the group.

State

Claim for allergy shot was incorrectly processed. System was set-up incorrectly. Claim was adjusted prior to our audit. (Overpaid $5.50)

Comment: BCBSMT agrees with this finding, however, disagrees with the payment error assessed. The system coding was corrected prior to the audit and an automatic system adjustment was performed to correct the affected claims.

II-3 RECOMMENDATIONS

- We identified 2 claims that the coinsurance and/or deductible was not correctly applied. BCBSMT has indicated that this is a system issue and is currently being reviewed.

  We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

  Comment: BCBSMT corrected these issues in September, 2006. We will investigate and discuss the materiality and resolution of those claims that have not been adjusted with the group.

- We identified 2 claims that were adjusted due to late charges or correction of pricing. Upon the performance of adjustments, the processor failed to apply the coinsurance provisions to the claims.

  We recommend that BCBSMT perform enhanced training in this area and conduct an analysis of all adjustments, in order to determine if other overpayments exist.

  Comment: BCBSMT will conduct follow-up training and investigate the magnitude of this issue. We will discuss materiality and resolution of this issue with the group.

ALLEGIANCE
BENEFIT PLAN MANAGEMENT, INC.

Ms. Marie Pollock
Wolcott & Associates, Inc
12120 State Line Road, Suite 297
Leawood, KS 66209

RE: Evaluation Claims Processing for the Period January 1, 2006 through December 31, 2007

Dear Marie:

This letter represents our response to the report issued in connection with the analysis and evaluation of claims processing of the Montana University System Traditional Plans for the period January 1, 2006 through December 31, 2007. The matters discussed herein were brought to the attention of the appropriate personnel

Audit Recommendations:

1. Incorrect Application of Emergency Room Co-Pays:

In order to insure that this error does not occur in the future, Allegiance has modified the system code for service code 1 or 21 with revenue code 450 so that the Emergency Room Co-Pay is waived in these instances.

Other Items of Discussion:.

1. Case Management:

The Audit Report refers to Allegiance's use of Rocky Mountain Health as a vendor for its case management services. Allegiance use's StarPoint LLC for all case management and utilization management services. Peak however, does use Rocky Mountain Health for its case management services.

2. Discounts:

Allegiance does not use "stacked networks". Please change all references of the term "stacked" to "tiered".

We believe the action we took is responsive to the recommendation of the review. Please let us know if you have any questions regarding our response or if you require further information.

Sincerely,

Ronald K. Dewsnup
President & General Manager

STATE OF MONTANA,
MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF MANAGED CARE PLAN CLAIMS PROCESSING FOR THE PERIOD JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

ADMINISTERED BY

NEW WEST HEALTH PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
PEAK HEALTH PLAN/ALLEGIANCE MANAGED CARE

FINAL REPORT

NOVEMBER, 2008

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE PLAN CLAIMS AUDIT
OF NEW WEST HEALTH PLAN, BLUE CROSS BLUE SHIELD OF MONTANA &
PEAK/ALLEGIANCE MANAGED CARE HEALTH PLAN
JANUARY 1, 2006 - DECEMBER 31, 2007

TABLE OF CONTENTS

EXHIBITS

I - INTRODUCTION

The State of Montana (State) provides self-funded Managed Care Plan as part of an overall employee benefit and compensation program. The plan covers approximately 3,000 employees and retirees, plus their dependents.

The State has negotiated a contract with New West Health Plan (NWHP), Blue Cross Blue Shield of Montana (BCBSMT) and Peak Health Plan/Allegiance Managed Care (PHP/AMC) to provide administration services to its plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and has also contracted to have their medical benefits administered by BCBSMT, PHP/AMC and NWHP. The plan covers approximately 1,000 employees and retirees, plus their dependents.

The State invited MUS to participate in an audit of NWHP, BCBSMT and PHP/AMC's processing of medical care claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years. Subsequently, our contract was renewed for the 2004-2005 and 2006-2007 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the contract would be renewed May 15, 2008. All preliminary work was completed and on-site services were performed in August, 2008.

On-site audit services were performed at:

New West Health Plan
130 Neill Avenue

Helena, Montana 59601

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Peak Health Plan/Allegiance Managed Care
2806 South Garfield Street
Missoula, Montana 59806

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care benefit claims paid by NWHP, BCBSMT and PHP/AMC during the period from January 1, 2006 through December 31, 2007. Test work was performed on 450 previously processed claims (150 claims per administrator), all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.
- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.

- Consistency of payments to member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

II - STATISTICAL CLAIM AUDIT RESULTS - NEW WEST HEALTH PLAN

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by NWHP between January 1, 2006 and December 31, 2007. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on NWHP's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that NWHP is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 2 were judged to contain a payment error. This represents a frequency of payment error of 1.3%. This is more favorable than the 4.7% error reported in the prior audit.

Our sample contained a total payment of $760,962.46 for the 150 claims. The overpayment totaled $54.32 or 0.01% of the total. The underpayment totaled $31.56 or 0.004% of the total. This financial error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the NWHP standard of 1%. In addition, it is more favorable than the 0.37% error rate reported in the prior audit.

The frequency of payment error in our sample is more favorable than the range of three to five percent error rate normally observed during our audits of similar plans. In addition, it is more favorable than the NWHP standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 2.2%, that the true frequency of error in the population does not exceed 3.5%.

Based on this extension, we believe that the true magnitude of payment error in the population is $181,095 or (0.41% of payments in the population). The magnitude of payment error is the sum of $0 in projected overpayments plus $181,095 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

A summary of error by type is presented below:

NWHP HEALTH CARE CLAIMS
JANUARY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of co-insurance and/or deductible.	1	$ 54.32
Incorrect application of copay provisions.	1	(31.56)
Total	2	$22.76

NWHP has included their response as **Exhibit D**.

RECOMMENDATIONS

Our recommendations are as follows:

- We believe NWHP has made significant improvements to the configuration issues identified in the prior audits. However, we did identify one claim that was overpaid caused by the configuration issues regarding deductible and coinsurance application. We recommend that NWHP continue running reports, in order to identify overpayments caused by the configuration issue. In addition, we recommend NWHP reimburse the State and MUS the amount of the overpayments identified.

III - STATISTICAL CLAIM AUDIT RESULTS - BCBSMT

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by BCBSMT between January 1, 2006 and December 31, 2007. Prior to selection, the population of claims was stratified.

All of the State claims are processed on the QNXT system. The MUS claims were converted to QNXT on 11/01/07. Therefore, 22 of the 24 months of this audit, the MUS claims were processed on the LRSP system. We did not have any QNXT processed claims for MUS in our sample.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).

- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 10 were judged to contain a payment error. This represents a frequency of payment error of 6.67%. The results were more favorable than the 11.3% reported in the prior audit report.

Our sample contained a total payment of $596,287.16 for the 150 claims. The overpayments totaled $424.04 or 0.07% of the total. The underpayments totaled $633.06 or 0.11% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 1%. In addition, the results are more favorable than the 1.58% reported in the prior audit report.

The frequency of payment error in our sample is less favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also less favorable than the BCBSMT standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 4.5%, that the true frequency of error in the population is within the range of 2.17% to 11.17%.

Based on this extension, we believe that the true magnitude of payment error in the population is $265,554 or (0.98% of payments in the population). The magnitude of payment error is the sum of $260,099 in projected overpayments plus $5,455 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Incorrect application of mammogram benefit.	2	$ (107.26)
Incorrect application of in-network benefits for non-network services.	1	155.09
Incorrect payment of lab charges.	1	12.51
Incorrect application of copay for inpatient services.	1	(400.00)
Incorrect application of coinsurance for inpatient lab charges for member who had satisfied the out-of-pocket limit.	2	(21.58) net
COB	1	42.83

Incorrect adjustment process performed. Adjustment should have applied remaining deductible.	1	7.09
Incorrect waiving of deductible and coinsurance for medical emergency services performed in the office.	1	102.24
Total	10	$(209.11)

BCBSMT has included their response as **Exhibit E**.

RECOMMENDATIONS

Our recommendations are as follows:

- We identified 6 errors caused by a QNXT system issue. Three of the six system issues had been identified by BCBSMT prior to our audit and adjustments had been made. However, the remaining 3 issues still need to reviewed and resolved by BCBSMT.

  One of the issues involves the application of lab charges to the deductible/coinsurance provisions of the plan document. These charges are being paid at 100%.

  The next issue involves the payment of claims at 100% when the deductible/coinsurance limits have not been satisfied.

  The final issue involves adjustment of claims. When an adjustment is performed, the system is not identifying whether or not the deductible/coinsurance limits have been satisfied.

  We recommend that BCBSMT review all the above mentioned QNXT system issues and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, we recommend that BCBSMT make the corrections to the system, in order to prevent these types of errors from occurring in the future.

- BCBSMT still utilizes the LRSP system for processing MUS managed care claims. We identfied 3 system issues relating to the LRSP system.

  One issue involved applying an inpatient copay based on the number of days a member stayed in the hospital.

The next issue involved the application of coinsurance for lab charges incurred during an inpatient stay when the member had already satisfied their deductible/coinsurance limits.

The final issue involved the payment of claims for emergency services rendered in an office setting at 100%, regardless of the satisfaction of deductible/coinsurance.

We recommend that BCBSMT review all the above mentioned LRSP system issues and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, we recommend that BCBSMT make the corrections to the system, in order to prevent these types of errors from occurring in the future.

IV - STATISTICAL CLAIM AUDIT RESULTS - PEAK/ALLEGIANCE MC

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 150 claims.

The claims were selected from the population of claims paid by PHP/AMC between January 1, 2006 and December 31, 2006. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 150 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on PHP/AMC's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that PHP/AMC is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 150 claims in our statistical sample, 0 were judged to contain a payment error. This represents a frequency of payment error of 0.0%. The results are more favorable than the 2.0% reported in the prior audit report.

Our sample contained a total payment of $1,116,994.40 for the 150 claims. The overpayments totaled $0 or 0.0% of the total. The underpayments totaled $0 or 0.0% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the PHP/AMC standard of 1%. In addition, the results are more favorable than the 0.021% reported in the prior audit report.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the PHP/AMC standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 0.6%, that the true frequency of error in the population does not exceed 0.6%.

Based on this extension, we believe that the true magnitude of payment error in the population is $0 or (0.0% of payments in the population). The magnitude of payment error is the sum of $0 in projected overpayments plus $0 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit C**. A discussion of error types is presented below.

A summary of error by type is presented below:

PHP/AMC HEALTH CARE CLAIMS
JANUARY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR

No Errors Identified.

PHP/AMC has included their response as **Exhibit F**.

DISCUSSION ISSUES

We identified 2 issues that warrant further discussion between PHP/AMC and the State and MUS.

- We reviewed a claim for dental service code D9430, which indicates an office visit for observation - no other services performed. We questioned the medical necessity of this claim.

  AMC indicated to us that since the member had not utilized the 2 oral exam maximum for the year, that they would pay this claim. In addition, they also placed a phone call to the dentist to inquire as to the services he rendered. In fact, the dentist did render services to the patient for a broken tooth. Therefore, AMC believed it would have delayed payment with no change in plan liability, AMC opted to pay as received.

  We believe that the dentist should have billed the codes that would have more accurately described the services that were rendered on behalf of the patient. In addition, we spoke to a Delta Dental Plan and they indicated that this service is considered non-covered due to the vagueness of the description of the code.

- The other issue involved the repricing of DME. Allegiance Managed Care had a contracted discount arrangement with this provider (it began as 8.8%, but was changed to 15% during the course of rental payments for the DME). We believe AMC should have only allowed rentals up to the purchase price minus the 15% discount, not the 8.8% discount.

  AMC disagreed with this assessment. However, we believe the member is being held accountable for more, since AMC is basing the purchase price on the lower discount rate.

  We believe that the State and MUS should discuss this situation with AMC as to how to handle the situation in the future.

V - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT, NWHP and PHP/AMC. This section describes the methods employed and presents the results of the verification of eligibility for the 450 (150 claims per administrator) in our sample where a payment was made by each administrator.

STATE OF MONTANA

The State prepares and sends to the vendors a biweekly eligibility tape showing each individual to be covered for the coming month. The administrators run this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

The administrator's receive the enrollment data from each campus on a daily basis. NWHP, BCBSMT and PHP/AMC then follow the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the administrator's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

VI - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 450 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the date the claim was processed.

Results, by plan sponsor, are presented below.

NWHP

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	12
Median	7
Mode	5

NWHP informed us that company policy for turnaround time is 14 day.

BCBSMT

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	4
Median	2
Mode	1

BCBSMT informed us that company policy for turnaround time is 97% claims are to be processed within 30 days.

PHP/AMC

For all 150 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	9
Median	7
Mode	4

PHP/AMC informed us that company policy for turnaround time is 14 days.

COMMENT

The turnaround time results for NWHP, BCBSMT and PHP/AMC do meet their own turnaround time standards and industry standards.

VII - HIGH DOLLAR CLAIM REVIEW

The results of our review in regarding each vendor's high dollar claim review is discussed below.

HIGH DOLLAR CLAIM REVIEW

BCBSMT

We reviewed the high dollar claim review process with BCBSMT. They indicated that all claims above $50,000 are subjected to audit by a senior manager. In addition, all line items in excess of $5,000 are subjected to audit by a senior manager.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

Allegiance

We reviewed the high dollar claim review process with Allegiance. They indicated that all claims processed with payment amounts between $10,000 and $25,000 are subjected to audit by an intermediate claims examiner. Claims that are processed with payment amounts between $25,000 and $100,000 are subjected to audit by the claims manager. Claims that are processed with payment exceeding $100,000 are subjected to audit by the director of claims.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

NWHP

We reviewed the high dollar claim review process with NWHP. They indicated that all claims processed with payment amounts greater than $10,000 and all institutional claims with payment amounts greater than $25,000 are held for quality review prior to releasing the payment. Once the payment has been reviewed by the internal quality auditor, the Claims Manager reviews and releases the payments.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

EXHIBIT A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - NWHP
AUDIT PERIOD JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

CLAIM TYPE	PLAN	AMOUNT PAID	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
I	MUS	-	54.32	(54.32)	Per plan, should have paid 100% after 15.00 co-pay. Claim was applied to the deductible.
I	MUS	622.50	940.50	(318.00)	Should have only applied a $75.00 co-pay. Took a co-pay of $106.56

EXHIBIT B

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - BCBSMT
AUDIT PERIOD JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
06016e03949	State	526.70	371.61	155.09	QNXT system issue. Claim originally paid in-network. However, provider was non-network. Claim was adjusted prior to our audit.
06363e04312a1	State	-	54.31	(54.31)	QNXT coding issue for mammograms. Claim should have been paid under the routine mammogram provision. Claim was adjusted prior to our audit.
07060e04849a1	State	-	52.95	(52.95)	QNXT coding issue for mammograms. Claim should have been paid under the routine mammogram provision. Claim was adjusted prior to our audit.
06174e04773	State	50.03	37.52	12.51	QNXT coding issue. Claim for lab charges were paid at 100%. The coinsurance should have applied for these charges.
06297006100	MUS	19,359.62	19,759.62	(400.00)	LRSP coding issue. Claim for inpatient hospital had a $400 copay applied. The patient's out-of-pocket and deductible were satisfied.
17268102790	MUS	13,933.98	14,059.81	(125.83)	LRSP coding issue. Claim for inpatient charges applied coinsurance to the lab charges. The patient's out-of-pocket and deductible were already satisfied. Claim was adjusted prior to our audit.
06130e03379	State	416.98	312.73	104.25	QNXT coding issue. This issue was corrected 1/1/07. The patient's out-of-pocket had not been satisfied. However, claim was paid at 100%.
06286e00332	State	1,081.20	1,074.11	7.09	QNXT adjustment issue. Claims had been adjusted, which affected the patient's deductible. This claim should have applied the remaining $7.09 for the portion of deductible that still needed to be met.
07296e04416	State	44.04	1.21	42.83	COB issue. Claim was not coordinated correctly with the primary carrier. Claim was adjusted prior to our audit.
16145317220	MUS	241.34	139.10	102.24	Coding issue in LRSP. System was set-up to waive deductible for services performed in the office with a medical emergency diagnosis.
Totals		35,653.89	35,862.97	(209.08)	

EXHIBIT C

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - PEAK HEALTH PLAN/ALLEGIANCE MANAGED CARE
AUDIT PERIOD JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE

NO ERRORS IDENTIFIED

NEW WEST
HEALTH SERVICES

130 NEILL AVE.
HELENA, MT 59601
406.457.2200

105 S.W. HIGGINS AVE.
SUITE 1
MISSOULA, MT 59803
406.829.2363

1203 HWY 2 WEST,
SUITE 45
KALISPELL, MT 59901
406.751.3333

2132 BROADWATER
UNIT A1
BILLINGS, MT 59102
406.255.0185

October 21, 2008

Wolcott & Associates, Inc.
Marie Pollock
12120 State Line Road, Suite 297
Leawood, Kansas 66209

Dear Marie Pollock:

New West Health Services reviewed the draft report for the State of Montana and Montana University System claims processing audit for the period January 1, 2006 through December 31, 2007. Other than the minor edits we provided via e-mail, New West has no additional comments.

Thank you for your continued audit work. Please call me directly at 406-457-2291 if you have any questions.

Sincerely,

Angela E. Huschka
Director of Finance and Administration

BlueCross BlueShield of Montana
An Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

560 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Customer Information Line:
1-800-447-7828
Website:
www.bluecrossmontana.com

November 24, 2008

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Managed Care Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana Managed Care claim audit recently completed for the audit period January 1, 2006 through December 31, 2007.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings in Exhibit B, and Recommendations.

Exhibit B

Group	
State	QNXT system issue. Claim originally paid in-network. However, provider was non-network. Claim was adjusted prior to our audit. (Overpaid $155.09) **Comment:** BCBSMT agrees with this finding, however, disagrees with any payment error being assessed. The system coding was corrected prior to the audit and an automatic system adjustment was performed to correct the affected claims.
State	QNXT coding issue for mammograms. Claim should have been paid under the routine mammogram provision. Claim was adjusted prior to our audit. (Underpaid $54.31) **Comment:** BCBSMT agrees with this finding, however, disagrees with any payment error being assessed. The system coding was corrected prior to the audit and an automatic system adjustment was performed to correct the affected claims.

State	QNXT coding issue for mammograms. Claim should have been paid under the routine mammogram provision. Claim was adjusted prior to our audit. (Underpaid $52.95) **Comment:** BCBSMT agrees with this finding, however, disagrees with any payment error being assessed. The system coding was corrected prior to the audit and an automated system adjustment was performed to correct the affected claims.
State	QNXT coding issue. Claim for lab charges were paid at 100%. The coinsurance should have applied for these charges. (Overpaid $12.51) **Comment:** The audit claim was for June 2006 date of service. Language in the 2006 Employee Annual Change Booklet (produced by the State of Montana), under Physician Services, Office Visits stated, "$15/ visit (no deductible some lab & some diagnostic included)". Through further discussion with the State, the BCBSMT interpretation of this benefit was deemed too broad. However, the State did not request adjustments to these claims. Language in the 2007 Employee Annual Change Booklet, was changed to state "$15 / visit (only includes basic preventive lab). BCBSMT changed the system coding (effective January 2007) to more accurately reflect the re-stated benefit.
MUS	LRSP coding issue. Claim for inpatient hospital had a $400 copay applied. The patient's out-of-pocket and deductible were satisfied. (Underpaid $400) **Comment:** BCBSMT agrees with this finding. BCBSMT has investigated and will discuss materiality and resolution of this issue with the group.
MUS	LRSP coding issue. Claim for inpatient charges applied coinsurance to the lab charges. The patient's out-of-pocket and deductible were already satisfied. (Underpaid $125.83) **Comment:** BCBSMT agrees with this finding, however, disagrees with any payment error being assessed. The payment error was identified and the claim was adjusted in QNXT and paid correctly prior to the audit.

State

QNXT coding issue. This issue was corrected 1/1/07. The patient's out-of-pocket had not been satisfied. However, claim was paid at 100%. (Overpaid $104.25)

Comment: The audit claim was for June 2006 date of service. Language in the 2006 Employee Annual Change Booklet (produced by the State of Montana), under Physician Services, Office Visits stated, "$15/ visit (no deductible some lab & some diagnostic included)". Through further discussion with the State, the BCBSMT interpretation of this benefit was deemed too broad. However, the State did not request adjustments to these claims.

Language in the 2007 Employee Annual Change Booklet, was changed to state "$15 / visit (only includes basic preventive lab). BCBSMT changed the system coding (effective January 2007) to more accurately reflect the re-stated benefit.

State

QNXT adjustment issue. Claims had been adjusted, which affected the patient's deductible. This claim should have applied the remaining $7.09 for the portion of deductible that still needed to be met. (Overpaid $7.09)

Comment: BCBSMT disagrees that this is an adjustment issue and also disagrees with the payment error assessed. The "adjusted claim" originally processed and paid in August 2006 (with a 2006 date of service). The audit claim processed and paid in October 2006 (with a 2006 date of service).

The "adjusted claim" was adjusted in April of 2007 and reduced the deductible amount by $7.09, which was applied in error according to the benefits of the contract.
Any future claims entering the system (after this adjustment) with 2006 dates of service would be subject to the $7.09 in outstanding deductible.

This is a timing issue only. Because the audit claim processed and paid in October 2006, prior to the adjustment on the "adjusted claim" there is no impact to it. If the Plan receives another claim for this member with dates of service in 2006, the remaining $7.09 will be applied according to the benefits of the contract.

State	COB issue. Claim was not coordinated correctly with the primary carrier. Claim was adjusted prior to our audit. (Overpaid $42.83) **Comment:** BCBSMT agrees with this finding, however, disagrees with any payment error being assessed. The original claim processed incorrectly due to clerical error. The Claims Entry Technician coded the COB payment incorrectly. This claim was adjusted and paid correctly prior to the audit.
MUS	Coding issue in LRSP. System was set-up to waive deductible for services performed in the office with a medical emergency diagnosis. (Overpaid $102.24) **Comment:** BCBSMT agrees with this finding. BCBSMT has investigated and will discuss materiality and resolution of this issue with the group.

III-4 RECOMMENDATIONS

1. We identified 6 errors caused by a QNXT system issue. Three of the six system issues had been identified by BCBSMT prior to our audit and adjustments had been made. However, the remaining 3 issues still need to be reviewed and resolved by BCBSMT.

   Recommendation: One of the issues involves the application of lab charges to the deductible/coinsurance provisions of the plan document. These charges are being paid at 100%.

   Comment: There were two claims in the audit related to this issue. The system had been coded (for services in 2006) to not apply coinsurance to lab services performed in conjunction with an office visit. This coding was deemed to be too broad and the coding was changed in January 2007 to better reflect the States processing requirements.

   Recommendation: The next issue involves the payment of claims at 100% when the deductible/coinsurance limits have not been satisfied.

   Comment: This issue is actually related to the issue above with lab charges paying at 100% when billed in conjunction with an office visit. As previously stated, the coding was changed in January 2007 to better reflect the States processing requirements.

Recommendation: The final issue involves adjustment of claims. When an adjustment is performed, the system is not identifying whether or not the deductible /coinsurance limits have been satisfied.

Comment: After further research, BCBSMT contends that this is not an adjustment issue as previously agreed to. This is strictly a timing issue. If and when another claim for this particular member comes in with a 2006 date of service, the remaining deductible /coinsurance limits will be applied in accordance with the contract benefits. See QNXT Adjustment Issue above.

Recommendation: We recommend that BCBSMT review all the above mentioned QNXT system issues and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, we recommend that BCBSMT make the corrections to the system, in order to prevent these types of errors from occurring in the future.

Comment: BCBSMT will review all the above mentioned QNXT system issues and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, BCBSMT will make corrections to the system were necessary.

---

2. BCBSMT still utilizes the LRSP system for processing MUS managed care claims. We identified 3 system issues relating to the LRSP system.

   Clarification: As of 11/01/07 BCBSMT processes all MUS claims in QNXT. No claims after that date have been processed in LRSP. Coding for the following issues identified is correct in QNXT.

   Recommendation: One issue involved applying an inpatient copay based on the number of days a member stayed in the hospital.

   Comment: The copays do no appear to correspond to the number of days the member stayed in the hospital. BCBSMT has investigated and will discuss materiality and resolution of this issue with the University System. System coding for these services is correct in QNXT.

   Recommendation: The next issue involved the application of coinsurance for lab charges incurred during an inpatient stay when the member had already satisfied their deductible/coinsurance limits.

   Comment: BCBSMT agrees with this issue and will investigate the magnitude. We will discuss materiality and resolution of this issue with the University System. System coding for these services is correct in QNXT.

Recommendation: The final issue involved the payment of claims for emergency services rendered in an office setting at 100%, regardless of the satisfaction of deductible/coinsurance.

Comment: BCBSMT agrees with this finding. BCBSMT has investigated and will discuss materiality and resolution of this issue with the University System. System coding for these services is correct in QNXT.

Recommendation: We recommend that BCBSMT review all the above mentioned LRSP system issues and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, we recommend that BCBSMT make the corrections to the system, in order to prevent these types of errors from occurring in the future.

Comment: BCBSMT will review all the above mentioned LRSP system issues and determine, through analysis, the magnitude of overpayments/underpayments that exist. As previously stated, as of 11/01/07 BCBSMT processes all MUS claims in QNXT. System coding for the issue stated above is correct in QNXT.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

- We identified an issue unique to the BlueCard program. If the allowance of a charge submitted through the BlueCard program is greater than the billed amount, BCBSMT will pay 100% of the charge, instead of applying deductible and/or coinsurance.

  We recommend BCBSMT discontinue this practice and conduct an analysis, in order to identify overpayments caused by this procedure.

  Comment: BCBSMT has investigated and will discuss materiality and resolution of this issue with the group.

IX – PRIOR AUDIT RECOMMENDATIONS

Data Entry

We identified 2 errors that were due to clerical (data entry) errors. We recommended that further training be conducted, in order to avoid these types of errors in the future.

BCBSMT Response: These issues were communicated to the individuals, and their Management reviewed the training issues with them.

QNXT Issue

We identified 2 claims that the coinsurance was not correctly applied. One of these errors was processed on the new claim system, QNXT. BCBSMT has indicated that this is a system issue and is currently being reviewed. We recommended BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

BCBSMT Response: The QNXT system fix applicable to the issue noted above was completed in September 2006, and an auto adjustment was performed on affected claims.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,

Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

ALLEGIANCE
BENEFIT PLAN MANAGEMENT, INC.

Ms. Marie Pollock
Wolcott & Associates, Inc
12120 State Line Road, Suite 297
Leawood, KS 66209

RE: Analysis and Evaluation of HMO Claims Processing for the Period January 1, 2006 through December 31, 2007

Dear Marie:

This letter represents our response to the report issued in connection with the analysis and evaluation of HMO claims processing of the Montana University System for the period January 1, 2006 through December 31, 2007. We are pleased to note that no errors or recommendations were made in the report and therefore we have made no response to any recommendations in this letter. There were however two items that were brought up for discussion and we have responded to those items.

Discussion Issues:

1. Repricing of Durable Medical Equipment (DME):

As Allegiance explained during the audit we believe this claim was processed correctly. When the claim was first submitted Allegiance was able to obtain an 8.8% discount. This discount was replaced on June 1, 2007 with a contact that allowed for a 15% discount on a prospective basis and did not allow for claims submitted prior to the effective date of the new contract to be reprocessed. Because of the fact that two separate contracts were in place at different times during the time this claim was being paid and because Allegiance was not allowed to reprocess prior claims under the new contract we continue to believe the claim was processed correctly and that the member received all benefits owing them. Below is a summary of the calculations on the claim.

Purchase Price of CPAP Machine	$1,335.00	
Billed by Provider	$1,467.00	
PPO Discount	148.90	(8.8% Discount until 06/01/07 then 15% Discount)
Denied Charges	214.50	(Exceeds purchase price)
Subtotal	$1,103.60	
Deductible	249.00	
Out of Pocket	48.03	
Paid by Plan	$ 806.57	

2. Dental Service Code D9430:

The auditor states that this claim should have been denied due to vagueness of the claim. Allegiance disagrees. The member visited the dentist to prepare for a tooth that eventually had a cap. This service is covered under the plan as is the initial visit. Because the claims examiner was familiar with the plan and denying the claim simply would have delayed payment with no change to the liability to the plan, Allegiance opted to pay the claim as received.

Please let us know if you have any questions regarding our response or if you require further information.

Sincerely,

Ronald K. Dewsnup
President & General Manager

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM,

PRESCRIPTION DRUG CLAIM AUDIT

FOR THE PERIOD

JANUARY 1, 2006 THROUGH DECEMBER 31, 2007

ADMINISTERED BY
CAREMARK

FINAL REPORT

NOVEMBER, 2008

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209

STATE OF MONTANA
AND MONTANA UNIVERSITY SYSTEM
PRESCRIPTION DRUG PLAN AUDIT
OF CAREMARK
JANUARY 1, 2006 - DECEMBER 31, 2007

TABLE OF CONTENTS

I - INTRODUCTION

The State of Montana (State) provides a prescription drug benefit as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered.

The State is a member of the Montana Association of Health Care Purchasers. The Association has negotiated a contract with Caremark to provide prescription drug benefits to employees and Association members that elect such benefits. The State has elected to have its prescription drug benefits provided by Caremark.

The Montana University System (MUS), has also contracted with Caremark for the provision of prescription drug benefits. The plan covers approximately 8,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2004-2005 Plan Years and subsequently renewed that contract for the 2006-2007 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Division advised Wolcott & Associates, Inc. that we had been awarded the audit contract. All preliminary work was completed and the audit process began September 15, 2008.

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Marie Pollock	Vice President	No
Brian Wyman	Manager	No
Richard Reese	Actuary	No

SCOPE OF AUDIT

The scope of audit services covered prescription drug benefit claims paid by Caremark during the period from January 1, 2006 through December 31, 2007. Test work was performed on 220 previously processed claims, 200 of which were selected on a stratified, random (statistical) basis and the remaining 20 were the top paid claims.

Scope elements included:

- Eligibility of claimants to receive payment.
- Calculation accuracy.
- Completeness of necessary information.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

COOPERATION WITH CAREMARK

We received a comprehensive audit scope from MUS and the State for the audit period. We requested the necessary documents from Caremark, in order to complete our audit, in mid-July, 2008.

As of the draft of this report, we have only received cooperation from Caremark regarding the claim audit portion of our services. After several attempts to obtain the other necessary information, we received no reply from Caremark. We have indicated the components of the audit scope in which Caremark was non-compliant with our requests in the following audit report.

II - STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 220 claims.

The claims were selected from the population of claims paid by Caremark between January 1, 2006 and December 31, 2007. Prior to selection, the population of claims was stratified.

The strata types were as follows: (1) Top 20 highest dollar amount and, (2) Electronic, paper or Mail Order (combined).

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on the plan's provisions in force as of the date the prescription was dispensed. Ingredient costs for electronic and paper (including out-of-network) claims were calculated based on Average Wholesale Prices (AWP) on the package size submitted or other applicable prices in effect on the date the prescription was dispensed. Ingredient costs for mail order claims were calculated based on AWP on package size submitted or other applicable prices in effect on the date the prescription was dispensed.

The percentage discounts, dispensing fees, and copayment amounts were compared to the plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan's requirements for:

- Exclusions,
- Pricing used at the time the prescription was dispensed,
- Recalculating payment amount,
- Appropriate copayment (generic, branded, etc.)
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations and,
- Eligibility of participant.
- Review of non-Caremark mail order claim processing

DEFINITION OF ERROR

All network pharmacy claim (electronic claims) payments were paid to the retail pharmacy. All mail order initial and refilled claim payments were paid to Caremark mail order pharmacy.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

AUDIT RESULTS

Of the 220 claims in our statistical sample, 14 were judged to contain a payment error. This represents a frequency of payment error of 6.4%. Of these 14 claims, 5 were overpayments, 8 were understating the member's out of pocket or deductible amount and 1 member was overcharged.

Our sample contained a total payment of $60,882.11 for the 220 claims. The overpayment totaled $ 41.19 or .068% of the total.

The sample's error magnitude, extended to the population, produces a projected overpayment of $229,079 (.34% of $66,860,654). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the sample strata.

As a result, we are 95 percent confident that the true value of the prescription paid claims during the period ranges from $68,971,698 (the $66,860,654 recorded claims, minus the $229,079 projected net error, plus the $2,340,123 value of the 3.5 percent precision) and $ 64,291,452 (the $66,860,654 recorded claims, minus the $229,079 projected net error, less the $2,340,123 value of the 3.5 percent precision).

The Caremark standard accuracy rate is 99 percent or more of the gross dollar payments should be paid accurately. We understand the measurement is made by summing the overpayments and underpayments, and dividing the result by the total dollars and subtracting from 100%.

The overpayments/underpayments percentage from our results (extended to the population) total 0.07 percent. This equals a payment accuracy rate of 99.93 percent. These results are superior to the Caremark standard accuracy rate. They are also superior to the 99%

accuracy standard established by other claim processors with which we are familiar.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

CAREMARK PHARMACY CLAIMS
JANUARY 1, 2006 THROUGH DECEMBER 31, 2007
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Understated the out-of-pocket amount.	7	$0.00
Incorrect day supply	1	9.89
Incorrect system coding	1	0.00
Did not calculate correct discount	5	31.30
Total	14	$ 41.19

Corrective Action

Caremark's response to our findings will be added to our final report as **Exhibit B**. For those errors with which we agree, they have assured us that corrective action either has been or will be taken for each identified error and that steps will be taken to reduce the frequency of the types of errors observed.

CONCLUSION

Based on our audit of 220 claims, we conclude that Caremark is not processing the State and MUS claims in agreement with the plan provisions. We recommend Caremark discuss these issues with the State and MUS and develop a plan of action to alleviate these types of errors in the future.

III - ELIGIBILITY

The State and MUS use various methods to report new entrants, changes and termination of coverage to Caremark. This section describes the methods employed and presents the results of the verification of eligibility for 20 of the claims in our sample.

STATE OF MONTANA

The State prepares and sends to Caremark a biweekly eligibility tape showing each individual to be covered for the coming month. Caremark runs this tape and compares it to the data for the prior month. An exception report is generated showing all errors in the file. The exception report is sent back to the State for correction or approval to load the file. If no exceptions were found, the file is loaded into the claim system.

MONTANA UNIVERSITY SYSTEM

Allegiance Benefit Plan Management, Inc. (Allegiance) processes claims for the MUS health care plan. Allegiance has also contracted to provide eligibility data to Caremark on behalf of MUS. Allegiance receives the enrollment data from each campus on a daily basis and transmits new entrant, change and termination data to Caremark electronically each day. An exception report is generated showing all errors in the file. The exception report is sent back to Allegiance for correction or approval to go ahead and load the file. If no exceptions were found, the file is loaded into the claim system.

ELIGIBILITY VERIFICATION

Caremark was noncompliant with our request regarding this subject.

Eligibility File Processing

Caremark was noncompliant with our request regarding this subject.

Eligibility File Accuracy

Caremark was noncompliant with our request regarding this subject.

Identification Cards Timeliness

Caremark was noncompliant with our request regarding this subject.

IV - LOGIC AND CLAIM TEST RESULTS

This section presents the results of test claims submitted to the Caremark claim system as a method of assessing the system's ability to identify inappropriate transactions.

LOGIC CLAIMS

Caremark was noncompliant with our request regarding this subject.

V - OTHER REVIEW ITEMS

Discussion regarding other claim review items are presented below.

PHARMACY NETWORK ACCESS

Caremark agreed, based upon census, that 100% of covered participants living in suburban areas will have access to at least one network pharmacy within five miles of the participant and 96.4% of covered participants living in rural areas will have access to one network pharmacy within fifteen miles of the participant.

Caremark was noncompliant with our request regarding this subject.

PHARMACY AUDITING

Caremark has two types of retail pharmacy audits: (1) Internal desk audits and (2) On-site field audits. After the claims go through a series of system edits, claims are the selected for a desk audit. Caremark agreed to field audit 10% of active network pharmacies each year of the contract. An active network pharmacy is defined as any pharmacy processing at least 400 prescriptions per year.

Caremark was noncompliant with our request regarding this subject.

PHARMACY PARTICIPATION

Caremark guaranteed that no more that 25% of the network pharmacies will voluntarily terminate their contracts with Caremark during any calendar year.

Caremark was noncompliant with our request regarding this subject.

CUSTOMER SERVICE RESPONSE TIME

Caremark guaranteed that a maximum telephone answering time averages less than 30 seconds for all customer service calls received. Caremark also guaranteed an abandonment rate of less than 5% for all customer service calls.

Caremark was noncompliant with our request regarding this subject.

REBATES

Caremark and Pharmacare merged in 2006 and Caremark took over the processing of MUS and the State claims.

The previous contract with Pharmacare indicated rebates in an amount to a 90% pass through with a minimum guarantee of $2.00 per rebatable retail prescription claim and a minimum of $5.25 per rebatable mail order prescription claim of the market share rebate received by Pharmacare.

The Pharmacare contract, dated January 1, 2006 and signed January, 2007, indicated that the rebate amounts were $4.00 per rebatable brand retail prescription claim and $17.80 per rebatable brand mail order prescription claim.

Caremark supplied us with copies of the "Rebate Distribution Summary by Client" indicating the number of prescriptions for both brand retail and brand mail order and the rebate calculation based on those numbers. This information was only supplied for 3rd and 4th quarter, 2007 and 1st quarter, 2008. We requested this information for the entire audit period. Caremark did not supply us with complete information.

Conclusion

Based on the information provided, we are unable to conclude that Caremark is in compliance with the terms of the contract as it relates to rebates.

PRIOR AUTHORIZATION/DRUG UTILIZATION PROCESS

We were requested to review several items as it relates to the prior authorization and drug utilization process.

Caremark was noncompliant with our request regarding this subject.

DENIED CLAIMS

We were requested to review the reason behind denials, provider type and whether or not there were multiple claims denied for one provider.

Caremark was noncompliant with our request regarding this subject.

MAIL ORDER PRESCRIPTION

Caremark guaranteed that 95% of all mail service pharmacist approved prescriptions will be shipped within an average of 2 business days from the date of receipt. Caremark guaranteed that 98% of all mail service pharmacist approved prescriptions requiring intervention will be shipped within an average of 5 business days from the date of receipt. Caremark also guaranteed

that electronic mail order claims will be processed with a 99% accuracy rate.

In addition, we were requested to review whether or not non-Caremark mail order claims are included in the rebate calculation and plan reporting

Caremark was noncompliant with our request regarding this subject.

SYSTEM CONTROLS AND ACCESS

We were requested to review the availability of the on-line claim processing system, including response times, and review Caremark's system of controls.

Caremark was noncompliant with our request regarding this subject.

PAPER CLAIM TURNAROUND TIME

We were requested to review the turnaround time for paper claims.

Caremark was noncompliant with our request regarding this subject.

WRITTEN INQUIRIES

We were requested to review whether or not written inquiries were responded to within 5 or 10 business days.

Caremark was noncompliant with our request regarding this subject.

REPORTING

We were requested to review the timeliness of quarterly and annual reports submitted by Caremark to the State and MUS.

Caremark was noncompliant with our request regarding this subject.

FORMULARY UPDATES

We were requested to review whether or not members were provided written notification, within 60 days, regarding the change of the formulary status of certain drugs.

Caremark was noncompliant with our request regarding this subject.

Exhibit A

STATE OF MONTANA
AND
UNIVERSITY OF MONTANA
PRESCRIPTION DRUG CLAIM AUDIT
CLAIMS PROCESSED FROM
SUMMARY OF FINDINGS

CLAIM #	STRATA	PLAN	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
20	2	MUS	903.38	892.64	10.74	Specialty drug that had an incorrect discount.
44	2	State	207.11	207.11	0	Understatement to the out of pocket amount by $40.00. Information provided was inadequate.
45	2	State	66.70	66.70	0	Understatement to the out of pocket amount by $40.00. Information provided was inadequate.
46	2	State	222.08	222.08	0	Understatement to the out of pocket amount by $40.00. Information provided was inadequate.
71	2	State	364.24	364.24	0	Understatement to the out of pocket amount by $20.00. Information provided was inadequate.
77	2	State	15.26	15.26	0	Understatement to the out of pocket amount by $20.00. Information provided was inadequate.
78	2	State	51.87	51.87	0	Understatement to the out of pocket amount by $20.00. Information provided was inadequate.
109	2	State	0.00	0.00	0	Understatement to the out of pocket amount by $14.74.00. Information provided was inadequate.
115	2	State	38.26	37.93	0.33	AWP less the discount is lower than the MAC pricing.
122	2	MUS	13.94	12.24	1.7	AWP less the discount is lower than the MAC pricing.
142	2	State	18.53	0.00	18.53	Incorrect pricing was not used.
174	2	MUS	0.00	0.00	0	System coding error made the member payment go to the out of pocket accumulator. However, the payment should have gone to the member's deductible.
215	2	State	0.00	0.00	0	Incorrect discount taken. Member was overcharged by $.58.
178	2	State	14.84	4.95	9.89	90 days supply received. However should have only been a 30 day supply.
			########	$ 1,875.02	41.19	

State of Montana & Montana University System Audit Response November 2008

CVS CAREMARK | CAREMARK

Introduction

Wolcott & Associates, Inc. (Wolcott) performed an audit on behalf of the State of Montana (SOM) and Montana University System (MUS), clients of Caremark (CM) for the period January 1, 2006 through December 31, 2007. The audit primarily focused on the areas of Claims Accuracy, Rebate Guarantees and Performance Guarantees.

CM has reviewed and researched the findings reported by Wolcott to determine whether, in our view, there are outstanding financial liabilities owed to our client and/or opportunities for process improvement. Below is our response to the findings reported by Wolcott & Associates.

Findings

Claims Accuracy

The auditors selected a sample of 220 paid claims from the claim experience tape provided by Caremark to determine whether claims were adjudicated in accordance with the contract in effect during the audit period. Wolcott reported a total of 14 claims believed to have been processed erroneously. CM's response to each of the 14 claims in question is included in Exhibit 1 at the end of this document.

Rebate Guarantees

Wolcott & Associates requested documentation to determine whether Rebates were calculated and paid by CM according to the guaranteed contracted rate of $4.00 per paid retail claim and $17.80 per paid mail brand claim.

CM provided the "Disbursement Remittance Advice" and "Rebate Distribution Summary by Client" reports for the quarters covered in the audit period. The information was reported in two different formats due to the migration of the clients from legacy Pharmacare to legacy Caremark. Both formats reported the total number of paid retail and mail claims processed for the quarter and corresponding payment calculated, based on the guaranteed rates noted above. Further details for each report is included below. CM also provided a summary report showing quarters, total rebates, check number and payment dates to tie this information with the reports. All rebate related information previously provided by CM has been included below.

Disbursement Remittance Advice: This report was generated from the legacy Pharmacare rebate system and covers the period from Q2 2006 through Q2 2007. Information for Q1 2006 was not able to be captured on this report and

alternately was provided via excel spreadsheet reflecting the same information contained in Disbursement Remittance Advice.

Rebate Distribution Summary by Client: **This report was generated from the legacy Caremark rebate system, which the clients migrated to after Q2 2007.** This report contains rebate information for Q3'07 through Q4' 07.

SOM and MUS Rebates Q106	Check Disbursement Summary	Rebate Reports Q206 thru Q207

Performance Guarantees

According to the SOM and MUS contracts in effect during the audit period, the information requested related to Performance Guarantees is out of scope for this audit. However, in the spirit of partnership, CM is working internally to compile a performance report card on the information requested which will be provided directly to the client for informational purposes only. This will be sent out as soon as possible, once we obtain all the necessary data from our internal partners.

Other

1. Logic and Claim Test Results

No details were provided to CM regarding Logic and Claim testing. CM is requesting additional information in order to determine what is required to complete this portion of the audit.

2. Drug Utilization Process

We are providing 10 DUR claims below as requested by Wolcott & Associates, Inc.

DUR Claims

3. Denied Claims

While CM believes the information requested falls outside of the scope of this audit, we have submitted a request internally to generate a customer report capturing the data requested. The report will be provided as soon as possible upon completion.

Summary

Based on our review of the findings reported by Wolcott, CM has determined that claim adjudication and rebate payments were made in accordance with the State of Montana and Montana University System Benefit Services Agreement and the Benefit Specifications in effect during the audit period. In our view there are no errors or recoveries due to State of Montana or Montana University System as a result of this audit.

EXHIBIT 1

STATE OF MONTANA
AND
MONTANA UNIVERSITY SYSTEM
CLAIM ACCURACY
FOR THE PERIOD 01-01-2006 THROUGH 12-31-07

SAMPLE CLAIM #	PLAN	WOLCOTT'S FINDING	CAREMARK RESPONSE
20	MUS	Specialty drug that had an incorrect discount.	A detailed response was previously provided in the screenshot file under sample claim #8, which included the same finding. Per Exhibit E in section C of the contract, schedule F (Specialty Drug Listing) pricing will apply only to claims which are filled at Pharmacare's Specialty Pharmacy (NABP 3958898). Although this drug was included on the listing in Exhibit F with a discount of AWP -17%, this claim was filled at a retail pharmacy and as such defaults to the contracted retail discount of AWP – 16%. We believe this claim was adjudicated in accordance with the contracted rate of AWP-16% and there is no financial impact.
44	SOM	Understatement to the out of pocket amount by $40.00. Information provided was inadequate.	An explanation was previously provided in the screenshot file under sample claim #28. This claim was filled under the mail order benefit. A complete listing of the mail order pharmacies, including NABP #s, was provided to Wolcott via email. Per SOM plan specifications, out of pocket and deductibles are not applicable under the mail order benefit. For a preferred branded drug filled at mail, a flat copay of $40 is required up to $400.
45	SOM	Understatement to the out of pocket amount by $40.00. Information provided was inadequate	An explanation was previously provided in the screenshot file under sample claim #28. This claim was filled under the mail order benefit. A

			complete listing of the mail order pharmacies, including NABP #s, was provided to Wolcott via email. Per SOM plan specifications, out of pocket and deductibles are not applicable under the mail order benefit. For a preferred branded drug filled at mail, a flat copay of $40 is required up to $400.
46	SOM	Understatement to the out of pocket amount by $40.00. Information provided was inadequate	An explanation was previously provided in the screenshot file under sample claim #28. This claim was filled under the mail order benefit. A complete listing of the mail order pharmacies, including NABP #s, was provided to Wolcott via email. Per SOM plan specifications, out of pocket and deductibles are not applicable under the mail order benefit. For a preferred branded drug filled at mail, a flat copay of $40 is required up to $400.
71	SOM	Understatement to the out of pocket amount by $20.00. Information provided was inadequate	An explanation was previously provided in the screenshot file under sample claim #28. This claim was filled under the mail order benefit. A complete listing of the mail order pharmacies, including NABP #s, was provided to Wolcott via email. Per SOM plan specifications, out of pocket and deductibles are not applicable under the mail order benefit. For a generic drug filled at mail, a flat copay of $20 is required up to $400.
77	SOM	Understatement to the out of pocket amount by $20.00. Information provided was inadequate	An explanation was previously provided in the screenshot file under sample claim #28. This claim was filled under the mail order benefit. A complete listing of the mail order pharmacies, including NABP #s, was provided to Wolcott via email. Per SOM plan specifications, out of pocket and deductibles are not applicable under the mail order benefit. For a generic drug filled at mail, a flat copay of $20 is required up to $400.
78	SOM	Understatement to the out of pocket amount by $20.00. Information provided was inadequate	An explanation was previously provided in the screenshot file under sample claim #28. This claim was filled under the mail order benefit. A complete listing of the mail order pharmacies, including NABP #s, was provided to Wolcott via email. Per SOM plan specifications, out of pocket and deductibles are not applicable under the mail order benefit. For a generic drug filled at mail, a flat copay

			of $20 is required up to $400.
109	SOM	Understatement to the out of pocket amount by $14.74. Information provided was inadequate	An explanation was provided in the claim # 28 that mail plan does not require out of pocket and deductibles. A complete listing of all mail NABP was provided via email. Per State of Montana plan specifications, there is no out of pocket and deductibles for mail service plan. For a mail service on a generic drug, only a flat copay of $20 is required up to $400.
115	SOM	AWP less the discount is lower than the MAC pricing.	This claim was adjudicated at retail as a MAC generic. Per Exhibit E section A of the contract, the retail pricing should be "The lower of Usual and Customary or: -Brand Drugs at AWP -16% +$1.95 Dispensing Fee. -MAC Generics at MAC + $1.95 Dispensing Fee. -Non-MAC Generics at AWP-16% + $1.95 Dispensing Fee." As this drug was included on the MAC listing at the time of adjudication, we believe this claim was adjudicated in accordance with the contract as a MAC drug and there is no financial impact.
122	MUS	AWP less the discount is lower than the MAC pricing.	This claim was adjudicated at retail as a MAC generic. Per Exhibit E section A of the contract, the retail pricing should be "The lower of Usual and Customary or: -Brand Drugs at AWP -16% +$1.95 Dispensing Fee. -MAC Generics at MAC + $1.95 Dispensing Fee. -Non-MAC Generics at AWP-16% + $1.95 Dispensing Fee." As this drug was included on the MAC listing at the time of adjudication, we believe this claim was adjudicated in accordance with the contract as a MAC drug and there is no financial impact.
142	SOM	Incorrect pricing was not used.	Additional information is needed from Wolcott in order to further research this claim.
174	MUS	System coding error made the member payment go to the out of pocket accumulator. However, the payment should have gone to the member's deductible.	The out of pocket amount and the deductibles were shown under the deductible on the screen shot that was provided to Wolcott. Since the out of pocket and the deductibles were not segregated in the screen shot, a separate screen shot of the Deductible accumulator and out of pocket accumulator showing the appropriate

			amounts that were deducted were provided. As indicated in the audit report, there is no financial impact associated with this finding, rather it is a classification error in the adjudication system. CM will follow up internally to correct the system display.
215	SOM	Incorrect discount taken. Member was overcharged by $.58.	This claim was adjudicated as a retail non MAC generic drug on 1-03-06. The new pricing structure for State of Montana went into effect as of 1-1-06. This claim was priced at AWP-15% and the newly effective pricing was AWP - 16%. We believe this occurred due to the timing of when the new pricing was coded in the system and will follow up internally to ensure this does not occur going forward.
178	SOM	90 days supply received. However should have only been a 30 day supply.	This is a COB plan under which members are eligible to receive up to 90 days of supply per State of Montana benefit plan specifications. We believe this claim was adjudicated in accordance with the contract terms and there is no financial impact.